Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: DR AHMED KHALIFA 1415 S HWY 6, SUITE 400D SUGARLAND, TX 77478	MFDR Tracking #: M4-09-7487-01
Respondent Name and Box #: INDEMNITY INSURANCE CO OF NORTH AMERICA Rep Box # 15	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "Firstly, the submitted diagnosis was exact diagnosis submitted for the date of service September 4, 2008 was paid. Secondly, there is no documented dispute regarding any of the submitted diagnosis."

Principal Documentation:

1. DWC 60 package
2. Total amount sought - $235.48
3. CMS 1500
4. EOB's
5. Medical Reports

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: The respondent did not submit a response to the request for medical dispute resolution.

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
5/15/2008 6/12/2008	99214	146	1-8	$0.00
Total /Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.203, titled ***Medical Fee Guideline for Professional Services*** effective for professional medical services provided on or after March 1, 2008, set out the reimbursement guidelines.

1. These services were denied or reduced payment by the Respondent with reason code:

   - 146-Payment denied because the diagnosis was invalid for the date(s) of service. The diagnosis code does not match up wit the documentation provided.

2. A review of the submitted medical bills indicates that the requestor billed two office visits coded 99214 for the treatment of the following diagnoses:

   - 724.2 – Failed back syndrome.
   - 719.49 – Pain in joint, multiple sites.
   - 719.44 - Pain in joint, hand.
   - 309.81 - Posttraumatic stress disorder.

   A review of the medical reports indicates the diagnoses: Chemical burns of 60% of his body; post traumatic stress disorder; and chronic pain.

   The respondent denied reimbursement because the diagnosis was invalid for the date of service, and it did not match up with the documentation provided. The Respondent does not identify which diagnosis code was the basis for the denial.

3. Division rule at 28 TAC §133.307(c)(2)(B), effective May 25, 2008, requires that the request shall include "a copy of each explanation of benefits (EOB), in a paper explanation of benefits format, relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB." This request for medical fee dispute resolution was received by the Division on April 6, 2009. Review of the submitted documentation finds that the requestor did not submit reconsideration EOB. The requestor provided evidence of carrier receipt of the request for an EOB. Therefore, the requestor has completed the required sections of the request in the form and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(c)(2)(B).

4. Division rule at 28 TAC §133.307(d)(2)(A)(i), requires "(A) The response to the request shall include the completed request form and: (i) all initial and reconsideration EOBs, in a paper explanation of benefits format using an appropriate DWC approved paper billing format, related to the health care in dispute not submitted by the requestor or a statement certifying that the carrier did not receive the provider's disputed billing prior to the dispute request." The respondent was notified of the dispute on April 14, 2009. The respondent did not submit a response to the request, reconsideration EOB, nor a statement certifying that the carrier did not receive the provider's disputed billing prior to the dispute request. Therefore, the respondent has failed to complete the required request form and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(d)(2)(A)(i).

5. Division rule at 28 TAC §133.307(e)(2), states "Issues Raised by the Division. The Division may raise issues in the MDR process when it determines such an action to be appropriate to administer the dispute process consistent with the provisions of the Labor Code and Division rules."

6. Division rule at 28 TAC §134.203(b), effective March 1, 2008, states "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section."

7. On the disputed dates of service, the Requestor billed for two office visits coded 99214. CPT code 99214 is defined as, "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family." The requestor did not document a detailed history or medical decision making of moderate complexity. The Division has concluded that the requestor did not meet 2 of the 3 key components required for billing CPT code 99214.

8. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. §134.203, §133.307
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is not entitled to reimbursement for the services involved in this dispute.

DECISION:

		11/20/09
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.